SECTION 2

Oral Maxillofacial Surgeon Services

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1 GENERAL POLICY

Oral maxillofacial surgeon services, as specified in SECTION 2, and dental services described in SECTION 3, are covered services of the Utah Medicaid Program. References: 42 C.F.R. 440.100, 440.120, 442.457, 442.458, 447.341, 483.460; Utah Department of Health Rule R455-20B.

Non-pregnant Adults Age 21 and Older

For non-pregnant adults age 21 and older, Medicaid will reimburse only for limited, emergency dental services. These include one limited oral evaluation, problem focused; an intraoral - periapical - first film, and an extraction, single tooth. Refer to Chapters 1 - 6, Diagnostic Services; 1 - 7, Radiographic Services, and 1 - 8, Oral Surgery Services.

Children, ages 0 through 20 and Pregnant Women

Children from birth through age 20 and pregnant women continue to be covered for the services described in SECTION 2,Oral Maxillofacial Surgeon Services, and SECTION 3, Dental Services.

1 - 1 Credentials

Oral Maxillofacial Surgeons licensed in the state where the services are provided may be reimbursed for services.

1 - 2 Clients Enrolled in a Managed Care Plan

A Medicaid client enrolled in a managed health care plan, such as a health maintenance organization (HMO), must receive all health care services, including medical supplies, through that plan. Refer to SECTION 1 of this manual, Chapter 5, Verifying Eligibility, for information about how to verify a client's enrollment in a plan. For more information about managed health care plans, refer to SECTION 1,Chapter 4, Managed Care Plans. Each plan may offer more benefits and/or fewer restrictions than the Medicaid scope of benefits explained in this section of the provider manual. Each plan specifies services which are covered, those which require prior authorization, the process to request authorization and the conditions for authorization.

All questions concerning services covered by or payment from a managed care plan must be directed to the appropriate plan. Medicaid does NOT process prior authorization requests for services to be provided to a Medicaid client who is enrolled in a capitated managed care plan when the services are included in the contract with the plan. Providers requesting prior authorization for services for a client enrolled in a managed care plan will be referred to that plan.

A list of HMOs with which Medicaid has a contract to provide health care services is included as an attachment to the provider manual. Please note that Medicaid staff make every effort to provide complete and accurate information on all inquiries as to a client's enrollment in a managed care plan. Because eligibility information as to what plan the patient must use is available to providers, a "fee for service" claim will not be paid even when information is given in error by Medicaid staff.

1 - 3 Clients NOT Enrolled in a Managed Care Plan (Fee-for-Service Clients)

Medicaid clients who are *not* enrolled in a managed care plan may receive services from any provider who accepts Medicaid. This provider manual explains the conditions of coverage for Medicaid fee-for-service clients.

1 - 4 Billing

Use ADA codes for all dental procedures and CPT codes only when there is not an applicable dental code. Dental services using ADA codes are billed using ADA accepted dental claim forms. The HCFA 1500 form must be used to bill when using CPT codes.

1 - 5 Definitions

Refer to SECTION 3, Dental Services, Chapter 1 - 3, Definitions.

1 - 6 Diagnostic Services

Refer to SECTION 3, Dental Services, Chapter 1 - 5, Diagnostic Services.

1 - 7 Radiographic Services

Refer to SECTION 3, Dental Services, Chapter 1 - 6, Radiographic Services.

1 - 8 Restorative Services

Refer to SECTION 3, Dental Services, Chapter 1 - 8, Restorative Services.

1 - 9 Endodontics

Refer to SECTION 3, Dental Services, Chapter 1 - 9, Endodontics.

1 - 10 Periodontics

Refer to SECTION 3, Dental Services, Chapter 1 - 10, Periodontics.

1 - 11 Prosthodontics

Refer to SECTION 3, Dental Services, Chapter 1 - 11, Prosthodontics.

1 - 12 Denture Adjustments, Repairs, Rebases, Relines

Refer to SECTION 3, Dental Services, Chapter 1 - 12, Denture Adjustments, Repairs, Rebases, Relines.

1 - 13 Oral Surgery

Refer to SECTION 3, Dental Services, Chapter 1 -13, Oral Surgery. In addition to the policy cited in that chapter, tooth reimplantation and/or stabilization of accidentally avulsed or displaced tooth and/or alveolus are covered for children only.

1 - 14 Orthodontia

Refer to SECTION 3, Dental Services, Chapter 1 - 14, Orthodontia.

1 - 15 Emergency Services

Refer to SECTION 3, Dental Services, Chapter 1 - 15, Emergency Services. In addition to the policy cited in that chapter, an oral surgeon should note the following instructions:

1. If a Medicaid client is assigned to an HMO, the HMO should be billed when the oral surgery procedure is the result of an accident or is an emergency. These procedures most likely will occur in an emergency room or hospital. Typically, these procedures can be billed using the CPT codes recently opened to oral surgeons. If the procedure is truly dental and not medical in nature and not the result of an accident, the procedure should be billed to Medicaid directly and not the HMO. For more information on clients assigned to an HMO, refer to Chapter 1 - 2, Clients Enrolled in a Managed Care Plan, and Chapter 1 - 3, Clients NOT Enrolled in a Managed Care Plan (Fee-for-Service Clients).

2. Remember, when billing Medicaid using CPT codes, use the HCFA 1500 form. If using dental codes, use the ADA form

1 - 16 Hospitalization for Dental Services

Refer to SECTION 3, Dental Services, Chapter 1 - 16, Hospitalization for Dental Services.

1 - 17 I.V. Sedation

Refer to SECTION 3, Dental Services, Chapter 1 - 17, I.V. Sedation.

1 - 18 General Anesthesia

Refer to SECTION 3, Dental Services, Chapter 1 - 18, General Anesthesia.

1 - 19 Oral Sedation

Refer to SECTION 3, Dental Services, Chapter 1 - 19, Oral Sedation.

1 - 20 After Hours Office Visit

Refer to SECTION 3, Dental Services, Chapter 1 - 20, After Hours Office Visit.

1 - 21 Billing for Supernumerary Teeth

Medicaid supports the nomenclature approved by the ADA for identifying supernumerary teeth. Please bill using the following tooth identifiers for supernumerary teeth:

Upper Right **Deciduous Teeth** **Upper Left**

Tooth #	A	B	C	D	E	F	G	H	I	J
Supernumerary #	AS	BS	CS	DS	ES	FS	GS	HS	IS	JS

Lower Right **Deciduous Teeth** **Lower Left**

Tooth #	T	S	R	O	P	Q	N	M	L	K
Supernumerary #	TS	SS	RS	OS	PS	QS	NS	MS	LS	KS

Upper Right **Permanent Teeth** **Upper Left**

Tooth #	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
"Super" #	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66

Lower Right **Permanent Teeth** **Lower Left**

Tooth #	32	31	30	29	28	27	26	25	24	23	22	21	10	19	18	17
"Super" #	82	81	80	79	78	77	76	75	74	73	72	71	70	69	68	67

2 NON-COVERED SERVICES

Refer to SECTION 3, Dental Services, Chapter 2, NON-COVERED SERVICES.

3 DENTAL INCENTIVE PROGRAM

Refer to SECTION 3, Dental Services, Chapter 4, DENTAL INCENTIVE PROGRAM. The Medicaid Agreement Letter is included with Dental Services.

4 DENTAL PROCEDURE CODES, LIMITS AND CRITERIA

Oral surgeons may use any of the covered codes for dental services, subject to any limits and criteria stated for the procedure code. Dental codes are listed in SECTION 3, Dental Services, Chapter 5, DENTAL PROCEDURE CODES, LIMITS AND CRITERIA. In addition to dental codes, oral surgeons may use the codes listed in this section of the manual.

4 - 1 Table Headings Defined

Code The code is the Health Common Procedure Code System (HCPCS) code used by Medicaid to identify the item or the "Y" code assigned by Medicaid. The procedure codes listed are the only ones accepted by Medicaid.

Age, PG "0 - 20" : This entry in the **Age, PG** column means payment will be made only if :
(1) the patient's age on the date of service falls within the age range specified [For example, "0 - 20" means from birth through age 20]
OR
(2) the patient is a pregnant woman.

"all": This entry in the **Age, PG** column means Medicaid covers the service or procedure from birth through any age, including non-pregnant adults.

Criteria The criteria listed are required by Medicaid before the item will be reimbursed and include criteria used by Medicaid staff to review a request for prior authorization.

Limits Any limits applicable to a procedure code.

P A **P A**, Prior Authorization, is approval given by the Division of Health Care Financing prior to dental services being rendered. If Prior Authorization is required for a procedure, code letter **T** or **W** will be in the P A column. If there is no letter in this column, prior authorization is not required.

When a dental code requires prior authorization, the procedure must be authorized by Medicaid BEFORE the service is given, except for emergency services. For authorization of emergency services, refer to Chapter 1 - 10, Emergency Services.

T - Telephone Prior Authorization: Call Medicaid Information and follow the telephone menu prompts.
In the Salt Lake City area, call **538-6155**.
In Utah, Idaho, Wyoming, Colorado New Mexico, Arizona, and Nevada, call toll-free: **1-800-662-9651**.
From other states, call **1-801-538-6155**.

W - Written Prior Authorization: Send written requests to:

MEDICAID PRIOR AUTHORIZATION
BOX 143103
SALT LAKE CITY UT 84114-3101

or use FAX NUMBER: **(801) 538-6382**

Coding Notes

Codes newly added to the list are in bold print.
A vertical line in the margin indicates where text or a descriptor changed for an existing code.
An asterisk (*) marks where a code is newly removed.

ORAL SURGERY SERVICES DENTAL CODES

Code	Description	Age, PG	Criteria	PA	Limits
D5931	Surgical Obturator	0 - 20			Only open to services provided by Primary Children Hospital Cleft Plate clinic dentist
D7260	Oroantral fistula closure	0 - 20			
D7285	Biopsy of oral tissue - hard (bone, tooth)	0 - 20			
D7410	Excision of benign lesion up to 1.25 cm	0 - 20			
D7411	Excision of benign lesion greater than 1.25 cm	0 - 20			
D7412	Excision of benign lesion, complicated	0 - 20			
D7413	Excision of malignant lesion up to 1.25 cm	0 - 20			
D7414	Excision of malignant lesion greater than 1.25 cm	0 - 20			
D7450	Removal of benign odontogenic cyst or tumor-lesion diameter up t0 1.25 cm	0 - 20			
D7451	Removal of benign odontogenic cyst or tumor-lesion diameter greater than 1.25 cm	0 - 20			
D7460	Removal of benign nonodontogenic cyst or tumor-lesion diameter up to 1.25 cm	0 - 20			
D7461	Removal of benign nonodontogenic cyst or tumor-lesion diameter greater than 1.25 cm	0 - 20			
D7465	Destruction, lesion	0 - 20			
D7520	Incision and drainage, abscess, extraoral soft tissue	0 - 20			
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	0 - 20			
D7540	Removal, reaction producing foreign bodies, musculoskeletal system	0 - 20			
D7550	Sequestrectomy for osteomyelitis	0 - 20			
D7560	Maxillary sinusostomy, removal, tooth fragment or foreign body	0 - 20			
D7610	Open reduction maxillary fracture, teeth immobilized	0 - 20			

The following codes are open ONLY to provider type 95 (oral surgeon).

Code	Description	Age, PG	Criteria	PA	Limits
D7620	Closed reduction maxillary fracture, teeth immobilized	0 - 20			
D7630	Open reduction mandibular fracture, teeth immobilized	0 - 20			
D7640	Closed reduction mandibular fracture, teeth immobilized	0 - 20			
D7670	Alveolus-stabilization of teeth, closed reduction splinting	0 - 20			Only open to services provided by Primary Children Hospital Cleft Plate clinic dentist
D7710	Open reduction maxillary compound fracture	0 - 20			
D7720	Closed reduction maxillary compound fracture	0 - 20			
D7730	Open reduction mandibular compound fracture	0 - 20			
D7740	Closed reduction mandibular compound fracture	0 - 20			
D7910	Suture recent small would, up to 5 cm	0 - 20			
D7911	Suture up to 5 cm, complicated	0 - 20			
D7912	Suture over 5 cm, complicated	0 - 20			
D7920	Skin graft, all information included	0 - 20			
D7950	Osseous graft, mandible	0 - 20			
D7955	Repair, maxillofacial soft/hard tissue defects, palatoplasty, for cleft palate	0 - 20			
D7980	Sialolithotomy	0 - 20			
D7981	Salivary gland excision, by report	0 - 20			
D7982	Sialodochaplasty	0 - 20			
D7983	Closure fistula salivary	0 - 20			
D9930	Treatment, complication, hospital, post surgical, unusual	0 - 20			

The following codes are open ONLY to provider type 95 (oral surgeon).

CPT CODES OPEN TO ORAL MAXILLOFACIAL SURGEONS

CPT Code	Description
11100	Biopsy of facial tissue
12001 - 12007	Simple repair of superficial wounds of scalp, neck, ... 2.5 cm or less to over 30 cm
12011 - 12021	Simple repair of superficial wounds of of face, ears, eyelids, nose lips and mucous membranes; 2.5 cm or less to over 30 cm
12031 - 12037	Repair–Intermediate, layer closure of wound of scalp, ... 2.5cm or less to over 30 cm
12041 - 12047	Repair–Intermediate, layer closure of wound of neck, ... 2.5cm or less to over 30 cm
12051 - 12057	Repair–Intermediate, layer closure of would of face, ears, eyelids, nose lips and mucous membranes; ... 2.5cm or less to over 30 cm
13120 - 13299	Repair–Complex, full thickness repair of scalp, neck, face, lips and mouth
20670	Removal implant superficial; e.g. buried wire, screw, plate
21029	Removal of contouring of benign tumor of facial bone
21030	Excision of benign tumor or cyst of maxilla or zygoma by enucleation and curettage
21040	Excision of benign cyst or tumor of mandible; by enucleation and curettage
21215	Graft, bone, mandible
21310	Close treatment of nasal bone fracture without manipulation
21315	Closed treatment of nasal bone fracture; without stabilization
21320	with stabilization
21325	Open treatment of nasal fracture; uncomplicated
21330	complicated, with internal and /or external skeletal fixation
21335	With concomitant open treatment of fractured septum
21336	Open treatment of nasal septal fracture, with or without stabilization
21337	Closed treatment of nasal septal fracture, with or without stabilization
21338	Open treatment of nasoethmoid fracture; without external fixation
21339	with external fixation
21340	Percutaneous treatment of nasoethmoid complex fracture, with splint, wire or headcap fixation, including repair of cathal ligaments and/or nasolacrimal apparatus
21343	Open treatment of depressed frontal sinus fracture
21344	Open treatment of complicated fontal sinus fracture, via coronal or multiple approach

The following codes are open ONLY to provider type 95 (oral surgeon).

CPT Code	Description
21345	Closed treatment of nasomaxillary complex fracture (LeFort II), with interdental wire fixation or splint
21346	Open treatment of nasmaxillary complex fracture (LeFort II), with wiring, local fixation
21355	Percutaneous treatment of fracture of malar area, including zygomatic arch and malar tripond, with manipulation
21356	Open treatment of depressed zygomatic arch fracture
21360	Open treatment of depressed malar fracture, including zygomatic arch and malar tripod
21365	Open treatment of complicated fracture(s) of malar area, with fix, multiple approach
21385	Open treatment of orbital floor “blowout” fracture; transantral approach
21386	periorbital approach
21387	combined approach
21400	Closed treatment of fracture of orbit, except “blowout; with out manipulation
21401	with manipulation
21406	Open treatment of fracture of orbit, except “blowout”; with our implant
21421	Closed treatment of palatal or maxillary fracture (LeFort I type) w interdental wire fixat.
21422	Open treatment of palatal or maxillary fracture (LeFort I type)
21431	Closed treatment of craniofacial separation (LeFort III type) use interdental wire fixation
21432	Open treatment of craniofacial separation (LeFort III type) with wire, internal fixation
21440	Closed treatment of mandibular or maxillary alveolar ridge fracture, separate proc.
21445	Open treatment of mandibular or maxillary alveolar ridge fracture, separate proc.
21450	Closed treatment of mandibular fracture; without manipulation
21451	with manipulation
21452	Percutaneous treatment of mandibular fracture, with external fixation
21454	Open treatment of mandibular fracture with external fixation
21461	Open treatment of mandibular fracture, without interdental fixation
21464	Open treatment of mandibular condylar fracture
21470	Open treatment of complicated mandibular fracture by multiple surgical approaches including internal fixation, interdental fixation, and.or wiring of denture or splint
21501	Incision and drainage, deep abscess or hematoma, soft tissues of neck
40490	Biopsy of lip
40510	Excision of lip; transverse wedge excision with primary closure
40520	V-excision with primary direct linear closure
40525	full thickness, reconstruction with local flap

The following codes are open ONLY to provider type 95 (oral surgeon).

CPT Code	Description
40527	full thickness, reconstruction with cross lip flap
40530	Resection of lip, more than one-fourth, with reconstruction
40650	Repair lip, full thickness; vermilion only
40652	up to half vertical height
40654	over one-half vertical height, or complex
40800	Drainage of abscess, cyst, hematoma, vestibule of mouth; simple
40801	complicated
40810	Excision of lesion of mucosa and submucosa, vestible of mouth; without repair
40812	with simple repair
40814	with complex repair
40816	complex, with excision of underlying muscle
41000	Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; lingual
41005	sublingual, superficial
41006	sublingual, deep, supramylohyoid
41007	submental space
41008	submandibular space
41009	masticator space
41015	Extraoral incision and drainage of abscess, cyst, or hematoma of floor of mouth; sublingual
41016	submental
41017	submandibular
41018	masticator space
41116	Excision, lesion of floor of mouth
41825	Excision of lesion or tumor, dentoalveolar structures, without repair
41826	with simple repair
41827	with complex repair

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Numerical by Code